DOI:
10.1007/s10728-019-00372-y

Document Version
Publisher's PDF, also known as Version of record

Health Care Analysis (2019) 27:157–170
https://doi.org/10.1007/s10728-019-00372-y

ORIGINAL ARTICLE

Austerity and Professionalism: Being a Good Healthcare Professional in Bad Conditions

John Owens[1] · **Guddi Singh**[1] · **Alan Cribb**[1]

Published online: 5 June 2019

Abstract

In this paper we argue that austerity creates working conditions that can undermine professionalism in healthcare. We characterise austerity in terms of overlapping economic, social and ethical dimensions and explain how these can pose significant challenges for healthcare professionals. Amongst other things, austerity is detrimental to healthcare practice because it creates shortages of material and staff resources, negatively affects relationships and institutional cultures, and creates increased burdens and pressures for staff, not least as a result of deteriorating public health conditions. After discussing the multiple dimensions of austerity, we consider the challenges it creates for professional ethics in healthcare. We highlight three mechanisms—intensification of work, practitioner isolation, and organisational alienation—which pose acute problems for healthcare professionals working under conditions of austerity. These mechanisms can turn 'routine moral stress' into moral distress and, at the same time, make poor care much more likely. While professionalism clearly depends on individual capabilities and behaviours, it also depends upon a complex sets of social conditions being established and maintained. The problems caused by austerity reveal a need to broaden the scope of professional ethics so that it includes the responsibilities of 'role constructors' and not just 'role occupiers'. Austerity therefore presents opportunities for health professionals and associated 'role constructors' to contribute to a reimagining of future models of healthcare professionalism.

Keywords Austerity · Ethics · Healthcare · Moral distress · Moral stress · Professionalism

✉ John Owens
john.owens@kcl.ac.uk

[1] Centre for Public Policy Research, King's College London, Waterloo Bridge Wing, Franklin-Wilkins Building, Waterloo Road, London SE1 9NH, UK

Introduction

This paper examines how the regime of fiscal austerity seen in the UK since 2010 has created working conditions for healthcare professionals that pose significant challenges for professional ethics. In part, this is because shortages of material and staff resources at a time of simultaneous cuts to complementary public services and deteriorating public health conditions mean that professionals are often working in overstretched and stressful conditions. But, in addition, austerity can be seen as part of a broader neoliberal political-economic culture that has imposed stricter managerial controls, raising the stakes for professionals while holding them more personally accountable for errors. Such conditions risk professionals feeling over-burdened, isolated from colleagues and alienated from their institutions and professional identities. In this way, austerity can turn the moral stresses routinely associated with healthcare work into experiences of moral distress. Austerity therefore generates significant ethical challenges for healthcare professionals as 'role occupiers', as well as for figures who act as 'role constructors'.

We begin by briefly drawing on the recent case of Dr. Hadiza Bawa-Garba to illustrate the severe problems faced by healthcare professionals working in highly stressful and overstretched conditions.

Healthcare Professionalism Under Stress: The Case of Dr. Bawa-Garba

Dr. Hadiza Bawa-Garba is a paediatrician who was found guilty of manslaughter by gross negligence after the death from septic shock of Jack Adcock, a 6-year-old boy with Down's syndrome, in 2015. We draw on the internal Investigation Report to present details of the case [1]. In doing so we are not taking a position on the full complexities of this particular case (i.e. we are not arguing that this is a clear-cut and direct example of the negative impact that austerity can have on paediatric professionalism), but we are suggesting that this example clearly illustrates the dangers that overburdened and highly demanding clinical practice can have for medical professionals, especially under managerial regimes that enforce strict personal accountability. The high profile of this case has led many doctors to identify with and reflect on the conditions in which Dr. Bawa-Garba was working and to question whether something similar could happen to them.

On 18th February 2011, Jack Adcock was admitted to Leicester Royal Infirmary Children's Assessment Unit (CAU) unresponsive and limp. Relevant to his underlying Down's Syndrome, Jack had previously had an operation to repair a significant congenital cardiac anomaly, and was being managed on a blood pressure medication called Enalapril. Dr. Bawa-Garba—a high-flying doctor with an unblemished record—was the paediatric registrar that day. As her paediatric consultant was absent, staff shortages meant that Dr. Bawa-Garba was requested to cover the CAU as well as her own ward duties and was responsible for Jack's care. The hospital was stretched in other ways too: IT failures disrupted test results; nursing shortages meant inappropriate use of agency staff for patients such as Jack; and insufficient

equipment created avoidable delays. Dr. Bawa-Garba worked for 12 hours that day without a break.

Jack was treated, initially, for gastroenteritis and dehydration and, after significant delay, with antibiotics for pneumonia (later confirmed to be the cause of death). Pressure to discharge patients from the ward meant constant rearrangement of patients. Later that evening Jack's mother administered an unprescribed dose of Enalapril. When Jack developed septic shock with organ failure and suffered a cardiac arrest an hour later, resuscitation was hampered by the mistaken belief that he was a different patient. Despite resumed efforts, Jack was pronounced dead at 9.21 pm.

Dr. Bawa-Garba was convicted for gross negligence manslaughter and struck off from the GMC medical register on 25th January 2018. She was reinstated in August 2018 after a successful appeal drew attention to the numerous extenuating circumstances she faced that day.

Whether or not the Bawa-Garba case is a direct result of austerity is, of course, contestable. Jack Adcock's death certainly took place at a time when many Trusts were facing real terms cuts in funding and Bawa-Garba was working in a context of staff shortages. However, the mistakes that took place and the contributing problems associated with staffing, resources and ward culture have been attributed to a number of other factors [1]. Thus whilst attributing direct causation between resource pressures and the mistakes that led to Jack's death is extremely difficult, the case does highlight the difficulties that many health professionals face when operating in overstretched conditions, and the severe consequences for clinicians who are held accountable for medical error. For this reason the case prompted powerful feelings of solidarity amongst many UK clinicians (within and beyond paediatrics) who have a strong sense that the constrained working conditions of the National Health Service (NHS) should sometimes count as mitigating factors for sub-optimal practice. It is to this broader concern that we now turn.

Healthcare Services Under Strain: The Multiple Dimensions of Austerity

Austerity has provided the fiscal architecture that UK public servants have worked within since the Conservative-led coalition government came to power in 2010. It is a term that was explicitly deployed by the government to describe the envisaged need for widespread financial retrenchment across the public sector in order to remedy the budget deficit created by 2008 financial crisis. Although the coalition government made a significant point of protecting the budget of the National Health Service (NHS) from cuts, an aging population and changes in demographics and disease burdens created significant financial pressures on health services. In the period since 2010 NHS average funding growth has been the lowest on record (1.3% per annum compared to an average of roughly 4% per annum in previous decades and at a time of growing need) [2]. This resulted in real terms funding cuts, putting huge pressure on the frontline staff.

The increased workload for staff can be seen in statistical data that demonstrates need for health and social care services outstripping supply.[1] Amongst other things, the immediate effects of spending constraints on frontline clinical services have resulted in: bed shortages with knock-on pressures to limit admissions or expedite discharges [6] delays and restrictions to clinical referrals [7]; insufficient numbers of staff present for shifts and rota gaps [8]; cuts to administrative and nursing staff leading to doctors having to take on more duties themselves and over time [9]; high workloads interfering with training and development [10].

Alongside shortages of material and staff resources for frontline clinical activity many complementary public services have suffered deep budget cuts, and these have indirectly contributed to the challenges that healthcare professionals face. For example, cuts to social security, including child, housing and educational benefits, alongside the implementation of service reforms associated with Universal Credit have led to sharp rises in issues associated with poverty [11]. Significant reductions to local authorities' operating budgets—with some seeing reductions of up to 40% [12] —have resulted in deep cuts to children's services, adult social care, transport and many other service areas which are pertinent to public and clinical health services. Focusing, for example, on child health, the period of austerity has seen: a predicted 40% of UK children living in poverty between 2015 and 2022 [13]; children's centres in England having had their budgets halved from £1.2 bn to £0.6 bn since 2010, with 508 children's centres closing in this time, 100 in London alone [14]; rising demands for child mental health services, with 1 in 10 children have a diagnosable mental health condition 9 years of increasing numbers of looked after children and rising demand for child protection services [15]. The major contribution of poverty and material deprivation to deteriorating public health conditions in the UK, particularly for children, has been widely reported [11, 16, 17] with the contribution that cuts to public services have made to poor health outcomes being highlighted explicitly [18–21].

The challenges austerity poses to professionalism in healthcare are not limited to economics; austerity has a strong socio-political dimension too. Despite protestations that there was no alternative, austerity has been characterised as a political choice that reflects the neoliberal agenda of the coalition government. Davies describes neoliberalism simply as a political-economic ideology that seeks the "elevation of market-based principles and techniques of evaluation to the level of state endorsed norms." [22]. In addition, many scholars have noted the strong cultural dimension of neoliberalism which has influenced social attitudes and behaviours [23, 24]. Austerity has enabled neoliberal norms and values—particularly those of individuality, accountability, competition, and personal responsibility—to penetrate deeper into the public life, influencing people's beliefs, attitudes, behaviours and relationships. This has been reflected and reproduced, for example, in the political rhetoric of austerity that has divided the public into "strivers

[1] For example: during the first week of 2017, more than 4 in 10 NHS hospitals (65 hospital trusts) declared a major alert [3]; A&E departments saw admissions grow 9.3% between 2013–14 and 2016–17 [4]; the period 2013–15 saw a 31% increase in delayed transfer of older patients in acute hospitals [5].

and shirkers" and encouraged acceptance of the withdrawal of benefits and services towards an "undeserving poor" [25].

The growing socio-cultural and managerial influence of neoliberalism on the norms and relationships within healthcare services has occurred at the same time as shortages of material and staff resources have led to a prevailing sense on the frontline of material scarcity. This might take the form, for example, of: anxieties over greater job insecurity; a sense of growing hopelessness; demands for what is needed imminently trumping attention to longer term planning; emerging cultures of blame; and a focus on results and outcomes over the quality of care. Such concerns are illustrated by falling levels of NHS staff morale and well-being since 2010 [26]. At the same time Health Education England have reported a crisis of recruitment and retention, with severe staff shortages in many areas [9]. Problems with long hours and limited pay progression have no doubt contributed, but so too have concerns about inadequate staffing levels, risks to patient safety, and rising concerns that staff will be held responsible for errors regardless of circumstances [27].

This sense of increased accountability has taken place alongside an erosion of autonomy for many health professionals. Neoliberal management regimes (for example, those associated with 'New Public Management' have delivered top-down forms of governance directed towards targets for and evaluation of performance, efficiency and safety which can stymie the discretion and autonomy of professionals [28]. Managerial power is amplified by demands that professionals do more with less while maintaining levels of quality and safety, backed up by threats of sanction for non-compliance. Austerity therefore establishes a particularly demanding set of institutional norms shaping contemporary health professionalism: tightening regulation and oversight requires staff to provide efficient, high quality and safe care despite growing material and staff scarcity, increasingly complex workloads, worsening pay, morale and development prospects and a pressurized, high stakes environments. Unsurprisingly, this can undermine cultures of solidarity and respect between frontline professionals. In contexts governed by rising stress, fear and precarity fellow health workers can feel in competition with each other, with each cadre of professional all too aware of the need to justify their own position and worth. This can make teamwork and collective decision-making more difficult at a time of crisis.

We should make clear that we are not seeking to explain what caused the conditions that led to Jack Adcock's death, nor are we suggesting that the conditions that Dr. Bawa-Garba experienced are a direct result of austerity. Rather, we introduce the case of Dr. Bawa-Garba because it vividly illustrates the problems faced by healthcare professionals operating in the sorts of challenging conditions that austerity is likely to create or exacerbate. Where professionals are overstretched and under-supported, with few resources to turn to, when things do go wrong cultures of personal blame and recrimination can arise quickly. Despite working in unsafe conditions, Dr. Bawa-Garba's case illustrates how attribution of personal responsibility can be prioritised over providing solidarity and support for a team member, with the criminalisation of her medical errors considered in isolation rather than as a part of a highly complex system. Ethical questions about what it means to be a good health professional in such conditions, how this can be achieved and indeed why anyone should

continue to aspire to be one are unavoidable. We consider these questions explicitly in the remainder of the paper.

The Ethical Challenges of Upholding Healthcare Professionalism in Conditions of Austerity

Austerity creates numerous problems for professionalism within healthcare. While it can affect extrinsic rewards (e.g. pay and status), more importantly, austerity can significantly diminish the intrinsic value of professional work because of the deterioration of conditions in which professionals are operating. This shapes our expectations of what it is reasonable to demand of professionals. There is no point expecting professionals to adhere to ethical principles and attain particular standards if their circumstances make these impossible to attain [29]. Reflecting about austerity ought to make us sensitive to the impact that challenging conditions have on professionals' capabilities and conduct. There is plenty of scope for disagreement about the linkages between structural conditions and the agency of professionals, but it makes no sense to ignore them.

The fundamental point here is that the very existence of professionalism depends upon complex sets of social conditions being put in place and maintained. Professionalism is both an expression of individual capability and of social organisation—both are required. (This is a theme developed in literature within both sociology and applied philosophy, which we have analysed elsewhere [30]). Professional roles are always constructed by and discharged within particular social conditions and relationships. This is not to say that individuals outside of professional roles cannot exercise expertise to bring about good ends, and do so with integrity, but outside of professional roles these things are not examples of professional ethics in the standard sense. Professional ethics is one way in which individual responsibility can be harnessed and developed but it is distinctive because it is embodied in specific socially defined, sanctioned and organised roles, settings and forms of authority. Part of the demand of a profession is that a practitioner can and will take individual responsibility (for example, be worthy of trust and capable of exercising leadership) even when operating alone, separated from their peers and/or working in over-stretched conditions; but, even in those circumstances, they still gain their bearings and legitimacy from their professional role. This is to flag up the fundamentally social character of professionalism: professional ethics cannot be enacted in the abstract, they must be situated in practice. We can insist on asking searching questions about the integrity of individual professionals but questions about the integrity of the social conditions of professionalism must be equally insistent. One important consequence of this is that the duties of those at the 'sharp end' of any human institution are dependent on the fulfilment of the duties of many others.

Professionalism is, therefore, contextually dependent. It is not a fixed, abstract essence but a historically situated, evolving and contested concept. Indeed, changes to the social character of professionalism over the last few decades have produced many concerns about the erosion of traditional professional values including the authority of professionals to determine the nature and ends of their work according

to standards they see as 'internal' to the activity in question. The increasingly managerial culture in healthcare (which we suggest has become heightened through the imposition of austerity) subordinates professional norms to organisational norms, defining professional activity in terms of whatever happens to be relevant to organisational success in a particular policy regime. In such cases professional autonomy and discretionary is replaced by 'standardization of work procedures and practices and managerialist controls [and] relies on externalized forms of regulation and accountability measures such as target-setting and performance review' [31]. In practice—in the UK but also in any system where the containment of resource use has become a central principle of healthcare organisation—growing managerialism combined with increased financial pressures have strongly shaped the conditions and possibilities of professional practice.

This institutional cultivation of budgetary and efficiency 'consciousness' is obviously a defensible strategy up to a point; however, it also carries clear risks of deleterious effects. The point at which financial constraint substantially undermines the conditions needed for professionalism is both a theoretical and empirical question, and will partly depend upon the conception of professionalism being deployed. However, on any reading of professionalism, there will come a point where financially determined organisational restrictions stifle professionalism and contort professional ethics.

Without being overly idealistic, or 'starry-eyed', about healthcare professionals they might, in relatively affluent health systems, reasonably expect conditions to be available that enable them to: (a) routinely provide threshold levels of adequate treatment and care; (b) have some capacity to identify and aim for high standards of treatment and care through, for example, (contributing to or harnessing) research and innovation; (c) work in an environment that supports effective teamwork and enables professional development including peer learning and support, and (d) have some time and space available to them to come to terms with, and help enact, evolving models of good practice. This is a fairly minimal sketch of expectations in which the various elements belong together. Offering effective and safe basic care in a routine way is a valuable thing but it cannot be enough—not least because professional expertise consists, in part, in questioning and reforming our conceptions of what counts as effective care. However, all of this—even the provision of routine basic care—is put under threat if the circumstances in which staff are operating restrict the possibilities of exercising and upholding professionalism.

Here we will briefly summarise three overlapping mechanisms through which the conditions of professionalism can potentially be undermined by financial pressures—intensification of work, practitioner isolation, and organisational alienation. This analysis has been generated by systematically setting the details of the Dr. Bawa-Garba case (and analogous examples) against theorisations of professionalism as a social accomplishment (including our own previous work on this theme [30]). We will outline the mechanisms separately but we are suggesting that they tend to work together in mediating between working conditions and the construction and exercise of professional roles and ethics.

Firstly, the intensification of work pressures is perhaps the simplest means through which standards of professionalism are put at risk. Under financial constraint

healthcare systems are continuously asked to deliver 'more for less' and this can get translated into an expectation that individual professionals are expected to do more and more. Under conditions of austerity the effect may be to concentrate a more substantial and complex workload into fewer hands. There is obviously a line at which this becomes unsustainable and harmful to both professionals and patients. Though this may be hard to discern, even operating on the 'right side' of that line is asking a lot from individual professionals. The sheer quantity of activity—both volume and number of tasks—drains physical and psychological resources and demands stamina and resilience which are not infinite. There is also the continual stress that work may, as a result, be undertaken with inadequate concentration or responsiveness to the particularities of cases or circumstances, especially as exhaustion sets in. These conditions can risk the more personal and subtle aspects of caring becoming 'crowded out' of clinical practices and relationships. At an individual level these conditions can lead to 'burn out' for individuals and staffing crises for healthcare systems even where there is in principle resource available to fill positions.

The three mechanisms we are discussing, taken together, change the character of professional work. But that possibility is discernible from this first point alone: intensification and the significant reduction in the availability of 'mental space' and time not only impairs one's ability to do a good job but also alters one's sense of the job being done. If there is insufficient time to engage properly with patients, or to reflect on the strengths and weaknesses of decisions and practices then this is likely to erode interest, motivation and personal fulfilment. It seems plausible to suggest that the pressures and effects of intensification may also undermine the capacity for, and sensitivity of, ethical discernment and reasoning. After all, tired minds are not the best minds.

Secondly, and relatedly, austerity can create conditions of isolation for practitioners which can threaten their work. Financial pressures, including deliberate efficiency measures and recruitment and retention side-effects, can lead to situations in which individuals are often working with much less 'back up' and/or in which—because of workload demands—they have much less time to communicate with one another. When and where isolation occurs it is a body blow to professionalism and professional ethics because these critically depend upon teamwork, collegiality and both peer review and support. A healthy professionalism will manifest itself in opportunities for individuals to 'compare notes' with one another and to look for informal (as well as formal) moral and technical support from colleagues. Conditions of isolation are therefore a threat to professionalism even before the potential perils of the more individualist, competitive, defensive and self-oriented attitudes that may be encouraged by harsher neo-liberal cultures are considered, though isolation may be amplified by such norms. The quality of ethical deliberation very often depends on creating conditions for dialogue and debate, whether in routine interaction or in more structured opportunities for organisations and professional groups to 'stand back' from immediate practical imperatives and mutually reflect on contentious or burdensome issues.

As with intensification, the risks of isolation are not purely on the quality of the work done but on the quality of life of practitioners. Relative isolation, especially when being challenged by growing demands, is liable to have a disastrous effect on

mood and wellbeing. Being chronically dismayed, anxious or depressed has serious consequences for the way one sees the worthwhileness and meaningfulness of one's role and hence poses a substantial cumulative risk to the sustainability and credibility of the system of which one is a part.

Thirdly, the loss of meaning and motivation may be compounded by (and perhaps most acute in relation to) a growing sense of alienation. Being subject to strong organisational norms is always liable to produce a degree of alienation, but the norms of pervasive managerial directives and regimes of 'efficiency' can easily introduce a gulf between practitioners' organisational identities and their vocational identities. This is possible, for example, when priorities are principally shaped by the demands of budgets, targets and algorithms rather than by context-sensitive professional expertise.

Conditions of austerity and its associated management techniques risk professionals feeling that they have become separated from the things that took them into their profession in the first place. Whereas with the first two mechanisms the prevailing sense might be that it has become much harder to do a good job, organisational alienation can create a sense that one's role has been taken away altogether and replaced by something else. When this happens then disillusionment, severe frustration or depression may not be very far away. It is not unreasonable for professionals to feel that they should be able to derive some fulfilment from performing well in their role. If this possibility is substantially reduced, or completely removed, so that workers can no longer live up to their idea of what it means to occupy and execute their professional role, their thoughts of leaving the profession are understandable, not least as a means of maintaining a vestige of personal (and professional) integrity [32].

Reframing Professional Ethics

These three overlapping mechanisms illustrate how practitioners can become decoupled from the professional communities, aspirations and bearings that help define and sustain them. They help to demonstrate how conditions of austerity can create significant ethical challenges for healthcare professionals.

There are circumstances in which we might reasonably hope for exceptional resilience and 'heroic' attitudes and practices from health professionals. In the context of emergencies, disasters or in war settings, we may hope that some health professionals will risk their own physical and mental health to do their job. But this cannot be a routine expectation. This is not just because human beings have limits, it is also because professional roles that do routinely require heroic practices (such as those found in the military) are underpinned by long-term approaches to education, infrastructure and profession building, and are typically dependent on strong institutional cultures and highly supportive conditions. Regular demand for a heroic level of performance from health professionals—particularly in conditions of austerity—will not only produce burn out for many but will undermine the sustainability of healthcare professionalism itself.

Elsewhere we have argued that normative arguments must be empirically informed and, more specifically, that claims about what agents ought to do must be informed by attention to the constraints and affordances that they face [33]. At least some of the time ethical analyses and conclusions should be informed by the view from 'inside the ethical landscape', that is with an awareness of the actual context and conditions agents face, rather than from some abstract and idealised position 'above' it. Understanding the impact that austerity has on the conditions faced by healthcare practitioners, particularly the institutional norms, supports and pressures that shape roles and experiences is therefore a key question for contemporary professional ethics.

Focussing in on the details and challenges of day-to-day working life for health professionals shows that they are always subject to 'routine moral stress' [34]. That is, they are invariably pulled in many different, and sometimes conflicting, directions by the demands of their roles. This may be challenging but is to be expected. Moral stress is not be equated with the emotional suffering or anguish that is normally captured by the term 'moral distress' (discussed originally in relation to nurses but increasingly being extended to doctors [35–37]), which arises in situations when it is practically impossible to do the things one judges one ought to do in providing healthcare. However the processes we have described—of professionals having to cope with more intensive and prescriptive managerial pressures at the same time that the illness burden that they are expected to respond to has grown—is a formula for multiplying levels of moral stress as demands and dilemmas become practically unmanageable and the maintenance of professional integrity potentially unsustainable. The product is almost certainly not only high levels of 'moral distress' but also severe risks to the quality of care provided.

The case of Dr. Bawa-Garba provides an illustration of this danger. Of course healthcare professionals must be held accountable, and their behaviour and actions subject to ethical scrutiny. However, evaluation of the conduct of healthcare professionals must take into account the conditions in which they are situated, particularly where these may be unmanageable. In other words in conducting our ethical analyses of professionalism we are not limited to a simple choice between assessing the professionalism demonstrated by individuals against abstract and ideal criteria, or focussing on the 'real world' circumstances and challenges facing frontline professionals in specific service contexts. We can also direct our ethical gaze and analyses onto the responsibilities of the people who help define and shape the roles of, expectations on, and conditions facing frontline professionals. This means directing scrutiny towards the policy makers, service leaders and managers, i.e. the 'role constructors', who have an ethical responsibility to create and protect the conditions of professionalism [38].

Attention to 'role constructors' can helpfully shift our analytical focus. Firstly, these people are themselves capable of understanding the linkages we have outlined, i.e. the causal and constitutive linkages between compromised working conditions and compromised professionalism. This would, we suggest, oblige them to pay close attention to, for example, questions about the feasibility of demands and the predictability of 'shortfalls', professional support systems and the re-thinking of models and processes of professional accountability. Acknowledgement of the relationship

between working conditions and professionalism also provides good reason for extending questions about accountability and responsibility from 'role occupiers' to 'role constructors'. This may stretch from institutional managers operating at a local level right the way up to the 'architects of austerity' within central government. These questions will not be easy to answer—as we have acknowledged, the causal link between macro political and economic structures, working conditions and professional conduct is complex—but they at least underline the need to view issues of professional responsibility in a nuanced and distributed manner and highlight the unavoidable social and political dimensions of questions of accountability. Secondly, the people we have in mind might quite reasonably wish to underline that they are also subject to severe structural constraints and are, in significant senses, in 'the same boat' as frontline professionals. Again, we suggest, that assuming such protestations were sincere and acted upon, the enhanced levels of solidarity this should engender would also be beneficial. Finally, and connected with this, there is no reason why the concept of 'role constructors' should not refer to health professionals themselves. Indeed this idea is central to 'occupational' (as opposed to 'organisational') conceptions of professionalism [31] —according to which the capacity and autonomy of professionals to help shape the conditions of their work is seen as a central plank of professionalism. Focusing on the ethics of role construction provides an invaluable opportunity, and a challenge, for health professionals to take responsibility for reimagining the nature of their roles as well as how those roles might be better governed and supported.

Conclusion

We have argued that the economic, social and ethical dimensions of austerity create highly problematic conditions for healthcare professionals to operate within. At its most severe, austerity can turn the routine moral stress that has always accompanied the work of healthcare practice into forms of moral distress. If sustained, this can compromise professional standards and the quality of care provided. Thus, not only does austerity bring risks to patients, it ultimately risks undermining the possibility of healthcare professionalism itself.

Consequently, we suggest that austerity provides important opportunities to reflect upon the challenges facing healthcare professionals: how and why is that which is of value in their work at risk, and how can this be protected? At its most expansive, this exercise could prompt a widespread reconsideration of the future of the healthcare professions themselves. Therefore, perhaps rather counter-intuitively, austerity could help healthcare practitioners and associated 'role constructors' to re-imagine and re-forge professional roles and identities within healthcare, and to push for working conditions which support the standards of professionalism to which they aspire.

This will obviously not be easy in the context of already overstretched conditions, with many professionals fighting to stay afloat. Change will require transformation from within, which may be fostered by healthcare professionals engaging in processes of ethical and political reflection. Such processes could, for

example, follow Navarro's [39] call for greater political engagement within and across the healthcare professions, and could involve consideration of the value of: renewed forms of education and professional development; strengthening professional relationships; broadening awareness of and engagement with public health concerns and the social determinants of health; developing alliances between professional bodies, patients' groups, academic researchers and civil society and broader social and political movements.

What is clear is that the conditions for healthcare professionalism imposed under austerity are creating significant risks and seem unsustainable. A critical and ambitious response to austerity, focussed on ethical questions about professional roles, relationships, working conditions and responsibilities, could enable those involved in delivering healthcare to reimagine and revitalize their work in ways that protect and promote their interests and those of the people they serve.

References

1. University Hospitals of Leicester. (2011). *Investigation report: Incident report form ref. no. W65737*. https://www.whatdotheyknow.com/request/460255/response/1128108/attach/2/FOI.SUI%20REPORT%20FOI%20Redacted.pdf?cookie_passthrough=1. Accessed 4 Feb 2019.
2. Stoye, G. (2017). *UK health spending*. Institute for Fiscal Studies. https://www.ifs.org.uk/uploads/publications/bns/BN201.pdf. Accessed 4 February 2019.
3. Watkins, J., Wulaningsih, W., Da Zhou, C., Marshall, D. C., Sylianteng, G. D. C., Dela Rosa, P. G., et al. (2017). Effects of health and social care spending constraints on mortality in England: A time trend analysis. *British Medical Journal Open.*. https://doi.org/10.1136/bmjopen-2017-017722.
4. National Audit Office. (2018). *Reducing emergency admissions*. https://www.nao.org.uk/wp-content/uploads/2018/02/Reducing-emergency-admissions.pdf. Accessed 4 Feb 2019.
5. National Audit Office. (2016). *Discharging older patients from hospital*. https://www.nao.org.uk/wp-content/uploads/2015/12/Discharging-older-patients-from-hospital-Summary.pdf. Accessed 4 Feb 2019.
6. Ewbank, L., Thompson, J. & McKenna, H. (2017). *NHS hospital bed numbers: Past, present, future*. The King's Fund. https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers. Accessed 4 Feb 2019.
7. Robertson, R., Wenzel, L., Thompson, J. & Charles, A. (2017). *Understanding NHS financial pressures: How are they affecting patient care?* The King's Fund. https://www.kingsfund.org.uk/publications/understanding-nhs-financial-pressures. Accessed 4 Feb 2019.
8. British Medical Association. (2018). *Medical rota gaps in England*. https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/influence/key%20negotiations/training%20and%20workforce/medical-rota-gaps-report.pdf?la=en. Accessed 4 Feb 2019.
9. NHS Improvement. (2016). *Evidence from NHS Improvement on clinical staff shortages: A workforce analysis.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/500288/Clinical_workforce_report.pdf. Accessed 4 Feb 2019.
10. Lind, S. (2017). Heavy workloads continue to get in the way of doctor training, warns GMC. *Pulse*. http://www.pulsetoday.co.uk/news/gp-topics/education/heavy-workloads-continue-to-get-in-the-way-of-doctor-training-warns-gmc/20034740.article. Accessed 4 Feb 2019.
11. Alston, P. (2018). *Statement on Visit to the United Kingdom, by Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights.* https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23881&LangID=E. Accessed 4 Feb 2019.

12. Hastings, A., Bailey, N., Bramley, G., Gannon, M., & Watkins, D. (2015). *The cost of the cuts: The impact on local government and poorer communities*. Joseph Rowntree Foundation. https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/Summary-Final.pdf. Accessed 4 Feb 2019.
13. Hood, A. & Waters, T. (2017). *Living standards, poverty and inequality in the UK: 2017–18 to 2021–22*. Institute for Fiscal Studies. https://www.ifs.org.uk/uploads/publications/comms/R136.pdf. Accessed 4 Feb 2019.
14. Gayle, D. (2018). More than 500 children's centres have closed in England since 2010. *The Guardian*. https://www.theguardian.com/society/2018/feb/20/childrens-centres-closed-austerity-council-cuts-tracy-brabin. Accessed 4 Feb 2019.
15. Association of Directors of Children's Services. (2017). *A country that works for all children*. http://adcs.org.uk/general-subject/article/a-country-that-works-for-all-children. Accessed 4 Feb 2019.
16. Gordon, D., Mack, J., Lansley, S., Main, G., Nandy, S., Patsios, D. & Pomati, M. (2013). *The Impoverishment of the UK PSE UK first results: Living Standards*. http://www.poverty.ac.uk/pse-research/pse-uk-reports. Accessed 4 Feb 2019.
17. Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M. & Geddes, I. (2010). Fair Society, Healthy Lives. *Institute of Health Equality*. http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review. Accessed 4 Feb 2019.
18. Lansley, S., & Mack, J. (2015). *Breadline Britain: The rise of mass poverty*. London: One World Publications.
19. O'Hara, M. (2014). *Austerity bites*. Bristol: Policy Press.
20. Royal College of Paediatrics and Child Health. (2019). *State of child health: England—Two Years On*. https://www.rcpch.ac.uk/resources/state-child-health-england-two-years. Accessed 4 Feb 2019.
21. Stuckler, D., & Basu, S. (2013). *The body economic: Why austerity kills*. London: Allen Lane.
22. Davies, W. (2017). *The limits of Neoliberalism: Authority, sovereignty and the logic of competition* (p. xiv). London: SAGE.
23. Harvey, D. (2005). *A brief history of neoliberalism*. Oxford: Oxford University Press.
24. Gilbert, J. (2016). *Neoliberal culture*. London: Lawrence & Wishart.
25. Hills, J. (2014). *Good times, bad times: The welfare myth of them and us*. Bristol: Policy Press.
26. Fletcher, E., Abel, G. A., Anderson, R., Richards, S. H., Salisbury, C., Gerard Dean, S., et al. (2017). Quitting patient care and career break intentions among general practitioners in South West England: Findings of a census survey of general practitioners. *British Medical Journal Open, 1,* 1. https://doi.org/10.1136/bmjopen-2017-015853.
27. Rimmer, A. (2017). Workload pressure no defence against clinical negligence, barrister warns. *British Medical Journal*. https://doi.org/10.1136/bmj.j2103.
28. Lapsley, I. (2009). New public management: The cruellest invention of the human spirit? *Abacus, 45*(1), 1–21. https://doi.org/10.1111/j.1467-6281.2009.00275.x.
29. Appiah, K. A. (2008). *Experiments in ethics*. Cambridge, MA: Harvard University Press.
30. Cribb, A., & Gewirtz, S. (2015). *Professionalism*. Cambridge: Polity.
31. Evetts, J. (2009). The management of professionalism: A contemporary paradox. In S. Gewirtz, P. Mahony, I. Hextall and A. Cribb (Ed.s) *Changing teacher professionalism: International trends, challenges and ways forward* (pp. 19–31) London: Routledge. 2009. p. 23.
32. Santoro, D. (2013). "I was becoming increasingly uneasy about the profession and what was being asked of me": Preserving integrity in teaching. *Curriculum Inquiry, 43*(5), 563–587.
33. Samuel, G., Cribb, A., Owens, J., & Williams, C. (2016). Relative values: Perspectives on a neuroimaging technology from above and within the ethical landscape. *Journal of Bioethical Inquiry, 13*(3), 407–418.
34. Cribb, A. (2011). Integrity at work: Managing routine moral stress in professional roles. *Nursing Philosophy, 12*(2), 119–127.
35. Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliffs, NJ: Prentice Hall.
36. Morley, G. (2018). What is 'moral distress' in nursing? How can and should we respond to it? *Journal of Clinical Nursing, 27*(19–20), 3443–3445.
37. Oliver, D. (2018). Moral distress in hospital doctors. *British Medical Journal*. https://doi.org/10.1136/bmj.k1333.
38. Cribb, A. (2009). Professional ethics: Whose responsibility? In S. Gewirtz, P. Mahony, I. Hextall, & A. Cribb (Eds.), *Changing teacher professionalism* (pp. 31–42). London: Routledge.
39. Navarro, V. (2008). Politics and health: A neglected area of research. *European Journal of Public Health, 18*(4), 354–355.